COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: CHILDREN'S HEALTH TECHNICAL ADVISORY COMMITTEE

September 11, 2019
2:00 P.M.
Health Services Building
Conference Room C
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Lisa Powell
CHAIR

Mahak Kalra
Donna Grigsby
Beth Savchick
Cherie Dimar
Michael Flynn
TAC MEMBERS PRESENT

Judy Theriot
Genevieve Brown
Ashley Runyon
MEDICAID SERVICES

CAPITAL CITY COURT REPORTING
TERRI H. PELOSI, COURT REPORTER
900 CHESTNUT DRIVE
FRANKFORT, KENTUCKY 40601
(502) 223-1118

APPEARANCES
(Continued)

Kevin Fow
WELLCARE

Cathy Stephens
Martha Campbell
HUMANA-CARESOURCE

Mendy Pridemore
AETNA BETTER HEALTH

Justin Johnson
ANTHEM

Jessica Beal
Cheri Schanie
PASSPORT

Kathy Adams
CHILDREN'S ALLIANCE

Tal Curry
OFFICE OF AUTISM

AGENDA

1. Welcome and Introductions

2. Establish Quorum

3. Approval of May/July Minutes

4. NEW BUSINESS
   * Autism Spectrum Disorder - Tal Curry
   * Updates from the MAC - Mahak Kalra
   * Roundtable Updates/concerns from each member/ professional organization

5. OLD BUSINESS:
   * DMS on Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
   * Psychopharmacological prescribing for KY children
   * School-based services and Free-Care Rule

6. MCO Updates/Questions or Data Request Reporting

7. General governance issues

8. Other Business

9. Action Items

10. Adjourn

DR. POWELL: Welcome, everybody, and we'll just first go around quickly and do introductions so everybody knows who is who.

(INTRODUCTIONS)

DR. POWELL: So, we're going to go a little bit out of order today just because Mr. Curry is here to present for us and he needs to move on elsewhere afterwards. So, we're going to start there.

So, those of you all who were here last time remember we were talking about different topics of concerns that the members had and autism is certainly at the top of many people's lists.

So, we made the decision to focus on autism and we invited Mr. Curry and also Dr. Barnes, and we actually are going to end up splitting this into this meeting and to the next meeting as well. Dr. Barnes had to cover a neurology clinic that was unforeseen. So, we will actually focus next time as well and he will present to us at that time.

So, with no further ado, if you want to go ahead and start us off.

MR. CURRY: Well, to give you a little context, I work closely with Dr. Barnes. Dr.

Barnes is the Co-Chair for the Kentucky Advisory Council on Autism Spectrum Disorders and I passed out two one-pagers. The first one is just a little bit about the office. It has our Vision and Mission Statement, the next committee meetings.

We've broken our work into three committees - Adolescent & Adult, School Age and Early Childhood. And I had served for years in the capacity of working with this Council, probably it even becoming a Council.

There was a group of interested providers, state partners that came together about 2011/2012 to create a coordinating committee and really did start looking at ways that we could partnership and do more to improve autism services across the spectrum, across a life span.

So, in 2016, the Council was made official legislatively. We had executive orders previously to that and we have a small budget, a $200,000 budget that includes yours truly, the office of one for the Office of Autism, but I work closely with a 28-member board that includes partners from U of L, UK, several other universities. We have self-advocates, family members, other key partners from across the state.

And, so, what I thought I would do is just touch on a little bit of what, maybe take one strength. So, on the second handout, I just came up with something quickly, and one of the things that we've struggled with since 2011 when we did a needs assessment across early childhood services in particular was looking at autism spectrum diagnostic work across the state.

And back in 2013, we probably had five to six centers, diagnostic centers including Weisskopf, looking at work over at UK, looking at EKU but there were very few doing diagnostic work across the state.

And since that time, I thought I would at least share with you just a rough map that I've come up with. It's a little bit confusing looking at the different partners but it includes community mental health centers, work from the University of Louisville Autism Center partnering with the Office for Special Health Care Needs creating several medical clinics and those are medical follow-up clinics.

One of them in Somerset does do some diagnostic work and they're looking at expanding that work to maybe having another center do some

diagnostic work soon as well, but the medical follow-up clinics is an opportunity for a multidisciplinary approach - a nurse. Dr. Barnes goes to several of these. We have a neurologist, a psychologist, psychiatric. We either have a psychiatrist or a developmental pediatrician that is involved with those.

And it's a nice way for folks not to have to just travel to Louisville. When you talk about autism services, a lot of times you're talking about families that travel to Cincinnati. I talked to one on the phone today. They go to Nationwide up in Columbus, Vanderbilt, other places.

But what's nice is we're starting to build some capacity. Are we where we need to be? No, but since 2013, we have four times more diagnostic and medical consultation clinics across the state which, when I show you a map and I didn't put it up here, the four to five, it was pretty sparse. So, it is nice that we have some different models of this work going on.

With some of these diagnostic clinics, we have some community mental health centers that have done some--Pathways is doing some really neat work around treatment and, then, they have two

clinicians that are doing diagnostic work. Mountain Comp has two clinicians doing diagnostic work.

Crossroads Autism Clinic which is a partnership with Kentucky River Community Care and it's a blended model from doing not just behavioral health but they have a medical model. They have a nurse practitioner there, as well as OT, psychologists and some other folks doing some work out of Hazard.

And, then, of course, CAPERS Clinic, Dr. Barbosa, a psychiatrist there at Cumberland River or Cumberland River Behavioral Health now has had a clinic for a while and they have some multidisciplinary work going on there as well and some diagnostic work. So, that's just a little bit of a highlight of those medical consultation clinics.

We also have had a neat partnership between the University of Louisville Autism Center, Weisskopf, and First Steps where they have, since 2015, they have been doing diagnostic work and triaging kids. They have a protocol to get kids, if you get in early enough, if you're into First Steps by age two, certainly a little bit before two and a half, there's the opportunity for the

service coordinators and the other primary level evaluator to look at autism and do some autism screening. And if that screening is indicated for further assessment, they have gotten protocol in place to get kids evaluated through Weisskopf very quickly. So, that's been a wonderful partnership and we'd had 250 kids since 2015/2016 get diagnosed there.

So, we are getting some more kids diagnosed earlier which has been a challenge across the state and is a challenge for many states.

I also just put down below just some estimates applied to our Kentucky Census Data to basically say there's no great data system to say here are all the kids who we know across the state have autism because autism is a medical diagnosis through the DSM-5.

We also have folks who are diagnosed through the school system and that is Educational Eligibility Criteria which is different. So, having one doesn't mean you have the other, and, so, there's a little bit of a challenge there keeping up with kids, but I can say that there's at least kids under 18, that 17,192 kids, there are, as of 2018, KDE has 7,580 kids as diagnosed and receiving

services for autism. Now, that doesn't include all the kids because you've got some kids under 12 and below, other areas, and I would probably say that we have 65 to 70% of the kids receiving services in school which is great.

Where it gets a little bit more challenging is the medical component to that because when you talk about treatment and you talk about services, a lot of folks are calling and the calls that I get are we just got diagnosed and we're getting on a wait list for Michelle P. Waiver and we've been told that that's what we need to do and we've got pretty significant needs and we're looking for ABA services or Applied Behavioral Analysis services.

That sometimes is what families do need. However, what we found is not all families do and it's been a struggle because we have families that are just waiting for services, waiting for services that they're not going to get anytime soon because we have a workforce capacity issue like we do in many areas, both physical and behavioral health.

So, one of the things I understood is that you all are looking at maybe some possible recommendations that I put down on the back

page. I know that one linkage that you all have already started on or one recommendation you made was to improve the access for Medicaid children to receive appropriate testing, assessment and intervention.

I don't know what all that included but the two areas that I would think about that are opportunities is certainly monitoring that approved testing and assessment.

So, Medicaid had put in some behavioral health codes for the expansion, if you will, or the ability for psychological testing not to just have to be done in an individual service arena where you just have one session.

Now you can code or you have the ability to do some coding for as a psychological associate or others to do some psychological testing and to do the written report and analysis but that just happened in January of this year. So, we'd have to be looking at data for that to see if we're starting to see that increase which is certainly one of the things that I'm interested in and the Council has talked about some.

Improving access to intervention. Like I said, we certainly have a need

for not just prevention and intervention services from a behavioral health or IDD standpoint but even physical health. So, occupational therapy, speech therapy, some of the same things that we've struggled with having limits in the state and providers, those limits certainly impact autism very greatly as well.

And I think in autism, typically, even though it's a large spectrum, we have some folks who are very significant. They have intellectual disabilities and their parents are looking at what am I going to do long term, what am I going to do as I get older, and it scares them and it's a challenge because we don't have as many IDD services that we would like to have with children, let alone even with adults.

And, so, there are families I think that struggle there. We know that some of those families don't have the means, don't have the access to not only just other resources to help them keep afloat and we know that some of those families are ending up, they have to declare their kids dependent and turn them over to DCBS. So, we know that we do get into those situations as well.

But as far as I think needs, I just started a list. Anything that we did in

Behavioral Health or IDD services basically, if we were to improve any of those areas, psychological testing to in-home therapy services which right now behavioral health-wise is a challenge because we don't have anything that really encourages in-home services, we don't have an increased rate for that, we don't have as many specialized services, that anything that this group were to recommend, it's going to help kids with autism.

And I am very passionate about kids with all disabilities, and when you talk about autism, you're crossing so many bounds. You're talking about speech, occupational therapy, working with the educational system and, then, working with your medical provider, but you're also talking about things like family support, respite, other things, other systems, Family First, DCBS is talking about that I think we're all in the same place, anything that we can leverage that other systems are doing.

So, I also come to you as the Executive Director and Council member for the Advisory Council for Autism, we're willing to make recommendations or look at ways to leverage other groups to say what are some areas, what are some low-hanging fruit, what are some possibilities.

I know when you go into making recommendations, it's also a matter of looking at what the data looks like and we've done some data collection but that is, again, I don't fault Medicaid, I don't fault anyone else, we just have a hard time identifying adults. In autism, if you look at adults in our state, autism isn't the primary diagnosis.

So, any person who has a behavioral health diagnosis, anxiety, whatever, it may not show up that they have autism. The same thing with children. We have a lot of children diagnosed with developmental delay.

We may have some children with anxiety but they still have autism and we know that there's a higher correspondence to looking at complex medical health needs as they continue to age, even if they are fairly productive citizens.

If they get the early intervention systems they need, folks with autism typically are ones that are going to be more expensive and are going to need some more complex medical health care needs. I know I'm preaching to the choir.

But I put that out there

because part of what is exciting, even if - and I'll jump back to the front page - we do have a couple of folks, a couple of our traditional ICFMR's that are doing some work with adults. They are now doing some complex medical services, outpatient services.

So, they're used to having folks with intellectual disabilities and those complex medical needs but they're opening their doors, and it hasn't really been advertised but it is increasing and I've been referring folks there as children age out.

I know Hazelwood, for example, they have a psychologist that's very passionate about this, Dr. Chaneb, who also has a child on this spectrum, and she is looking at that transition age population, how can we do more, also crisis stabilization services, those sorts of things.

So, I think there's some pockets of some really neat things going on. How do we continue to support that and build and encourage those innovative ways that families are making it work in our systems.

And a lot of our work with the Council goes back to building up family support, some of those lower-cost and educational opportunities

because so many people, even this listing of providers, I've started to create a list to share with others because so many people don't know. Crossroads has people from Hazard traveling to Somerset to do diagnosis, and Somerset has people traveling.

And if you know anything about folks who are wanting to get a diagnosis, they get on as many lists as they can if they're an active parent. They're going to go to the first-come/first-serve, and if they can, they will drive clear across the state, but, then, it is good to know they may have some services that are more accessible in their area for ongoing medical follow-up or maybe psychology, maybe psychiatric needs, medication and whatnot.

So, we are trying to build a better connection amongst these different groups that are doing diagnostic and some treatment work but that's a start and we know that this was a need. We know the next step is, okay, we've got to do better as far as treatment.

So, I could stop there. A through J is pretty much, whatever you look at as far as systems, they are things of behavioral health,

they are things that DCBS, they are things that most systems are talking about - the in-home community-based services, the rural provider issue.

Yes, we have several providers that say they cover, just like some of our community mental health centers, that cover all the counties, but the reality is if you live in a very rural county, you're going to be lucky to find services. You're going to be lucky to find - I know this from my previous work in Early Childhood Mental Health - we at one point had the capacity to say we had people that would see kids under age five with behavioral health services.

I would say right now, at least when I left the Department for Public Health, looking at those services, we did not because we've got providers but, at the same time, we haven't figured out how to incentivize, how to make those connections.

And I know there's been some folks who have made headway with making individual contracts through MCOs in some of those very rural areas for providers, but typically we're still struggling with families need in-home. They need more than just someone touching base at school even

and most of them, transportation, getting to the outpatient office, just like you all who are providers, the show rates are difficult.

So, I'll stop. I could keep going on but I'm open to whatever your all's dialogue has been around autism or questions you have and start to answer some of those and see if there's some areas where you all see some interest and other groups that are paying attention to these needs as well.

DR. POWELL: I have lots of questions but I'll see if anybody else wants to start first.

MS. KALRA: Yes. I have lots of questions as well.

MS. BROWN: I have a question for our representatives from the MCOs. Do you all have any data sets involving your identified Autism Spectrum Disorder patients? Do we have any numbers on that? Do we know?

MS. CAMPBELL: I think we're all saying we'll go back and check. I know that we do. I just don't know the frequency or formats.

MS. BROWN: Right. I was just wondering about how close these estimates are to what

our MCOs might see in their population. And I know that you're not necessarily overseeing the waiver program which is where I guess we concentrate some of our services for those people, but I just was curious about what information we might have. If you could provide that to us, I think it would be helpful.

DR. POWELL: So, maybe we can have that for next time since we're going to also focus on autism next time as well, if we could have a little bit of an update.

MS. KALRA: Before we move forward, can we clarify how they're supposed to get those numbers to us?

MS. STEPHENS: I think you're supposed to request it through Angie Parker.

MS. BROWN: Okay.

MS. KALRA: Okay. I just want to make sure we follow up accordingly.

MS. BROWN: I'll check with Angie and make sure she knows I asked the question.

MS. STEPHENS: I think she'll send it out in a formal request.

MS. KALRA: DO you want us to reach out to you with that?

MS. BROWN: You can copy Angie

and me with any responses. It would just be helpful for the next TAC, I think. Thank you.

DR. POWELL: So, I wonder if you can just clarify, do you all have any data yet on where we are in Kentucky with deferred diagnosis, how long is it taking once kids are referred before they are evaluated and receive the diagnosis, if one is appropriate?

MR. CURRY: I don't know that we can say. Every one of these locations, and I've gone out and visited most of them or been on the phone with them, they do that differently.

So, you have some who are community mental health centers that may have a therapist who is seeing two to three, four families a month and that's it but it's multiple sessions that they get started with.

It may take six weeks when it's all said and done because they need to have them in three, four times for individual sessions, not only do the initial intake but, then, to do an ADOS-2 if they're doing that. Hopefully they may do some other psychometric data and, then, pulling the report together and, then, sharing that and, then, sharing recommendations.

I think wait list-wise, there are significant - and I can't speak to what Weisskopf is at right now but it's fluctuating anywhere between six months to a year. They triage every once in a while and, then, the list builds back up. And they certainly have been a strong partner in saying we don't want to do it all. We need places that are triaging.

And, then, when we reach those times when we need to look at other diagnostic criteria or look at other genetic components and get other testing completed, that we get folks to Weisskopf or get them to other genetic services at UK and elsewhere.

DR. POWELL: I just wondered if we could get some of that. There's been some interesting national data about that, about the time for deferred diagnosis. I just didn't know where we stood in that.

I was also sort of thinking just in terms of a population health perspective, if still the bottleneck is wait list and time to referral, if we could maybe think about other places where we could do screening, like primary care.

So, personally, where I am, we are doing that. I don't know if you would have a sense of how many other primary care pediatric clinics are doing that; but from a pub health standpoint, that certainly seems to make a lot of sense.

DR. GRIGSBY: I think most primary care folks are screening but it's getting that next step to a more definitive diagnosis where we're running into trouble.

DR. POWELL: So, not just the M-CHAT or even just an interview, but I know in a lot of other states - and we started using the STAT here and I know First Steps started using the STAT, but lots of primary care clinics across the country use the STAT.

It's a much more powerful tool than a screening, than the M-CHAT where parents aren't always great reporters, not because they don't want to be but because what we're saying - do they point to show you things or do they bring things to do you. Well, maybe to get their needs met but not for social purposes - very different if you're talking about a two-year-old.

So, it's just maybe something

that we could think about just in terms of being able to address and screen for many more kids. I mean, everybody is in primary care.

MR. CURRY: And, then, that triage on the other end, are there things that different diagnostic clinics are doing. One of my hopes is to bring these groups together to have quarterly calls or at least semi-annual calls to talk about ways that we can collaborate, ways we can look at positive, what are some of them doing to do some triage because you still have a lot that are coming in with--there's a lot of trauma out there. We have the opioid epidemic and weeding out those folks to then get to their appropriate services and referrals is important, too, and most of these folks are doing both at this point.

DR. POWELL: So, when you all started and trying to, especially in other parts of the state that just don't have as many options, so, is there a protocol that they use when they're doing----

MR. CURRY: There's not a standard protocol. We have really pushed the ADOS-2 and having everyone utilize that as a standard and, then, it's best case that they also have a

multidisciplinary team, not that every team member is going to see every child because that's not a good use of resources, but that they're there in that consultation format.

And that's where sometimes it gets tricky because there's only so much that providers can bill on and that multidisciplinary we know is very helpful but it's also a challenge how you bill and how you make it economically work.

DR. GRIGSBY: The other issue that I know I've personally run into as a provider is there's some insurance companies that will not approve services until you've got that ADOS, even though you may have had some other recognized form of appropriate testing.

I had a patient that the insurance would not pay for services until they had an ADOS. So, that's a barrier that I think we run into. Even if you're getting children into other places to get tested, they're not getting appropriate services because their insurer is holding up the process.

DR. POWELL: That's why I was wondering about was there a protocol because there is a gold standard protocol for assessing which includes

cognitive, adaptive, ADOS, all of those things, but if we don't use that, then, it's not helpful because then they can't access.

MR. CURRY: And that's true because we do have those folks that walk into our behavioral health offices or our primary care clinics and we don't need an ADOS. I mean, it's pretty clear, but the issue, then, becomes either the insurance or the schools, we're not going to just take because Dr. Grigsby said here's this diagnosis without her having the additional testing to show that.

MS. KALRA: Okay. If you have more questions, go ahead.

DR. POWELL: That's okay. Go ahead.

MS. KALRA: One question I did have was you mentioned that there are some codes that Medicaid has developed recently or approved in January.

MR. CURRY: In January, they included with behavioral health some ABA codes, as well as increased - and I don't know if this is the right word for it - diagnostic psychological codes that allow for additional billing. So, a typical

psychologist, and I wouldn't say just psychologists, although I think that's where Medicaid has landed because other people can utilize some psychometric instruments including the ADOS-2 doesn't have to be done by a psychologist, but that report writing and stuff, they can ask for that to be billed under so that they can recoup some of that time because a big barrier had been folks just doing it. You come in, here's your individual session and I do the best that I can to start it and we do the ADOS here, we do it here and it takes longer.

MS. KALRA: So, it is billable.

MR. CURRY: That's my understanding as of January 1. The codes started January 1 but they didn't come out until February.

MS. KALRA: Okay. And, then, it's only for psychiatrists and psychologists?

MR. CURRY: I'd have to look back. It's psychologists primarily and psychological associates.

DR. POWELL: Yeah, and neuropsych testing. We've talked about it a little bit in here because, like you said, they came out, CMS, but, then, it took a bit before we were up and running using them. It really is a different way to

bill; but in the example that you were talking about where it's separated in that way, I can see. If the same person isn't writing the report or you're starting with the diagnostic interview and someone else is doing the testing and someone else, I could see that would make it maybe different.

I will speak personally. There aren't other psychologists here who can say that, but it hasn't really changed the way--it's really just changed the CPT code and the way that we use the CPT codes and now we add on rather than it is that it covers services that it didn't cover before.

It used to be that the codes sort of everything was included and that testing, report writing, anything else, and now it's sort of separated out.

MS. KALRA: Okay. So, do you feel like there's folks from your association and your peers feel like they know it's available and have been using it?

DR. POWELL: We have to. The old codes went away. There's still lots of things nationally and certainly in this state and I've sort of brought that up a couple of times since January saying what are we hearing about our codes because in

our association for sure, people are saying what's happening with our codes. So, it's a major shift for us, more in terms of practice, I think, than covered services is my take.

MS. KALRA: Great. The other question that I had was around you also mentioned crossover leveraging other piles of federal funding that we have or utilizing some support, whether it's Family First. Is that something that we could--can we tap into Family First? Is that something that we should be recommending?

MR. CURRY: That would be a conversation with DCBS, but my understanding is there could be some opportunities looking at prevention for some families, especially being a part of that dialogue. And I don't know how expansive that dialogue has been, but it certainly is something to look at, the prevention aspect which I think a lot of what we're talking about is prevention efforts.

And even some of the pilots, some of the work that we've done with the Council has been around trying to build up some low-cost training to give to professionals and even have family peer support specialists and other folks be able to train on and say, okay, you've got this diagnosis but it

doesn't change little Johnny and little Sally. You still love them the same way and trying to work through here are some basic environmental, here are some basic behavioral, here are some other basic things that you can do in lieu of or in waiting for more intensive services.

MS. KALRA: It seems like that could be like a short-term just recommendation and seeing if there's a crossover and recommending folks to come at the table and speak.

DR. POWELL: You were mentioning the in-home piece and how hard that is. I so agree and we see that every day how much of a need.

Can you give us an update first on waiver stuff and what you're advising families about that and maybe that's a huge opportunity, too, for in-home services because we struggle with that mightily and I know there are so many families that's such a great need.

MR. CURRY: Well, as I advise families as newly diagnosed, at least I can say there's so many variables that go into that. Locally, what are the resources, what's available, but the short and long is we know that so many of

them are hearing, oh, I need to get on the waiver. Well, please get on the waiver wait list but know that that's some significant time. It's not that you shouldn't but please don't wait for those services and you need to be able to explore out there what are some of those services.

And I think some folks have done a better job of exploring and looking at behavioral health services. There's more capacity in some areas, but you still run into there's not much in-home, not much community support kind of work going on that we really need I think with this intensive population, and not just this one but many.

DR. POWELL: So, people with maybe more specialized training, too, because I certainly see that, too. We can refer for in-home, but if they don't have experience with kids on the spectrum, it's really not real productive. So, that's a workforce issue.

MR. CURRY: It's a workforce-- well, we have the workforce issue, I think. We work a lot with community mental health centers but we also work with the folks who are in BHSO's, multi-service providers, but at the end of the day, building up that capacity, it's hard when turnover is

high. How much do you invest in? How much do you-- and we do have systems that are doing a better job and doing more intensive training and there are some online and other opportunities out there for training and getting experience.

I usually say for folks, a lot of times people equate it sometimes in my experience in early childhood, people are afraid to see kids under five.

Well, if you learn how to work with families, you can do work with kids under five because it's working with the families more intensively. Building a relationship is still building a relationship, whether you're an IDD provider or a behavioral health provider and most of the work is building those relationships with those families and building relationships with the children you're serving, knowing that that takes time and knowing that it's intensive.

It is hard doing it always in an outpatient setting but that's certainly one of the things that we've talked about in our group is how do we increase that, how do we increase even youth or family peer support services, other modalities that may not be as expensive but might be other avenues to

help support families.

MS. RUNYON: Can I chime in because I'm seeing a crossover. So, we brought up Family First and I'm not exactly sure how Family First would tie in exactly other than the fact that Family First is working to expand capacity and specifically building capacity for in-home services for like therapeutic foster homes where children have the same challenges and the same parental burnout rate, if you will, just for the sheer stress that goes with caring.

And, so, in my mind, the way that Family First is potentially going to cross over with this is just in that advocacy to expanding capacity across the board because this capacity is needed in several different.

And instead of like looking at this as all in silos, if we're advocating for it across the board and more able to really express the need for there to be a capacity, then, you can recruit for a workforce if you know you're going to be able to utilize them.

MR. CURRY: And honestly part of this struggle is, so, you take Michelle P. Waiver and you take services, we only have so many ABA

therapists out there or people doing that in-home behavioral support work.

Well, the rate is "x" for them, but if the rate is "y" over here in behavioral healths services, we're not going to move anybody over to behavioral health services when they can make more money over here.

And part of it, I think, is some conversations about we only have so many folks that can do this work, not only bringing more capacity to the state but sometimes I think we make the mistake of putting too much money into high-need services that sometimes, like--I could go on and on with some of the possible behavioral health or the Medicaid waiver redesign, but there are lots of families that are hopeful that that will produce more slots because there will be more to go around and maybe less than per child out there.

But I think until we start looking at - and I've struggled with this since 2014 - where has the monitoring been since 2014 of targeted case management, of crisis intervention services, for crisis intervention across the board, in-home services, you name it, and we've not really looked at those numbers instead of at what are we

doing to really improve services because they are the same kids.

I mean, when you talk about autism, if you make improvements to any of the system, it's going to make benefits----

MS. RUNYON: Improvements to several.

MR. CURRY: Yes. High quality fidelity, targeted case management, the HIFI wraparound. I know it's more expensive but we know that there are families, it works.

MS. RUNYON: So, hopefully, what Family First prevention will do for not just the population of out-of-home kids, it will also cross over because we're trying to strengthen the evidence-based practice programs. We're trying to strengthen those and make sure that those are the ones that we are utilizing in both capacity.

MR. CURRY: And these are the same kids that are ending up in psychiatric hospitals or the end of the day, they're adults who are sometimes ending up on DCBS' doorstep because families can't take care of them anymore, but we didn't do anything to support them. And it's not just us. It's education work. We're basically

preparing kids for the couch, not for careers. How do we do a better job of that and sometimes I look at the Medicaid waiver redesign and I'm like, if you put the money towards supporting employment in redesign, then, you're going to build up supporting employment because people are going to start building that and working towards it versus a lot of behavioral supports, not that people don't need behavioral supports but we need people out there working and we've got lots of folks that can work in SCL, Michelle P and across the board and our folks who have disabilities.

DR. POWELL: What other questions do people have? One last question. I wonder if you have some school data on how many of our kids, especially the early childhood population - I mean, I always think about those kids - and this is totally anecdotal - so, I'm wondering if you have data on how many kids are going in already established diagnosis versus kids who are coming in.

It feels to me like more and more kids are entering preschool without a formal diagnosis and then they're waiting because of that and, then, the difference between the educational eligibility and a----

MR. CURRY: Yes. And nationally the numbers are still not where we want them to be. If we want diagnosis to be by age two instead of four, five, six on average but it's gotten better.

It's a slow process but I think we are seeing more and we are seeing the struggle around some folks saying I can't send my child to preschool because I need more intensive than just a half day four days a week and that's across the board with lots of kids with behavioral health needs.

They aren't necessarily going to state-funded preschool because there's not transportation unless they have a good wraparound program where they have wraparound child care and, then, folks that understand how to work with folks with disabilities and that's I think community by community.

There's more in some communities. There's more in communities you would be surprised by in some of the rural areas, and, then, some of the urban areas, you go, oh, why don't they have "x" and they don't have it.

DR. POWELL: How about through First Steps? I know you said that you all had been

working on the partnership with First Steps, your office and Weisskopf in particular. How about, are there changes in First Steps or an update in terms of how they are managing kids? I mean, obviously, all their kids have developmental delays but that certainly has changed in terms of the process for autism evaluations.

MR. CURRY: It used to be four or five years ago, five years ago, they did not have hardly any kids diagnosed with autism under age three and now they've got 250. So, it's a start. It's not what it probably needs to be but it is increasing those numbers.

And I think they're doing a much better job of triaging those kids, getting them diagnosed and, then, starting the services, although a lot of folks, we still are not getting kids in at one and a half, two, and the earlier they're in, the more chance there is for the intervention prior to age three and the intervention looks so different when you get to state-funded preschool age.

And, then, I think it becomes more of a blend between what can you access in the medical field for OT, speech and some of the behavioral health needs, as well as and we have

communities that have that, local rehab hospitals and other places and then others that don't, but, then, you run into the same shortage of OT, speech therapists and whatnot.

MS. BROWN: I have a question and I'm not a health care practitioner. My background is in law. So, this might seem like a very ignorant question to some of the medical minds in here, but are there any preventive efforts, is there any identified prevention that the medical science has identified for autism or is it still very mysterious, the causes?

I really honestly don't know. I mean, I was wondering, is there anything in an education and wellness and prevention mind set that we can do to prevent the onset of it? I know that sounds possibly very ignorant, but looking at what you're describing, to me, it looks like an increasing public health, potentially expensive because these people are aging and need more care.

And, so, I'm just wondering what the science is, if there is any. So, forgive me if that sounds naive but I just have no idea.

MR. CURRY: There are some philosophical differences in that. There are still

families and still groups that want to find a cure, and there are also folks who totally embrace the fact that they're autistic. We have several autistic groups in the state who label themselves as I'm proud to be autistic. It's my neuro diversity. This is who I am.

So, I'm careful when I answer that question because the science, there's not anything that says, oh, here's how we prevent.

MS. BROWN: Okay. I kind of had that idea but I wasn't sure where science is with that right now.

MR. CURRY: I think it's more embracing the neuro diversity of all children. And when I think about autism, I passionately have kids from the foster care system that I've adopted - fetal alcohol syndrome looks very similar to autism. It's not autism but a lot of the services and the challenges with services I've personally faced.

I've had to pay out of pocket for a lot of services. I pay out of pocket for services because there's not ongoing therapists and good quality therapists staying at community mental health centers, Cardinal Hills, you name it. We were lucky in First Step services. We were lucky here.

So, it's hard for families to negotiate that. And I think at the end of the day, it's also a workforce development and an economic issue because we've got a high percentage of families that are--I talked to three this week already who are staying at home, at least one of the family members is, and they're caring for their child because they don't have enough of the services to keep afloat and they're still navigating education, medical services, spending time being the case manager.

And I, then, try to, are there case managers at the MCOs that might be more helpful that I know work more towards autism or work more with some of that foster care population because some of them overlap there, trying to get them connected.

MS. BROWN: Do the FRYSCs - I can't remember what it stands for - do they have a role in coordinating care or identifying providers or helping families with this diagnosis? Do you know? I'm not sure.

MR. FLYNN: Any of your Family Resource Centers would have a list of resources. And if families are concerned about that or if schools do some kind of a pre-screener, then, if those families were needing assistance in finding those resources,

they would provide those resources to them.

MS. BROWN: Are schools identifying this? I mean, do teachers say, hey, could somebody screen----

MR. FLYNN: Their school psychologist could screen for it.

MS. RUNYON: I will say that that does come with a parent agreeing to have their child screened. So, there are some barriers in that because there's not education and it has not been fully embraced everywhere.

While a teacher can see what would seem to be obvious signs that a child needs to be screened, if the school counselor or school psychologist reaches out to that parent and that parent says, no, I do not want my child screened, then, the school doesn't have the ability to offer any type of special education services underneath the umbrella of an IEP.

Hopefully, Free Care will allow for kiddos to receive maybe some more services without them being identified through a screener.

And as for the Family Resource Coordinator question, even if a Family Resource Coordinator has access to every single resource

within a 100-mile radius, if there's not capacity, then, I think we're still looping back around to the barrier.

MS. SAVCHICK: In addition to that, the preschools with the quality program - you know, you've got the Stars Quality Program - involves screening the children. So, the parents give permission because they're in the quality program but that's a developmental screener, say, the AXQ, but there is an ASQ:SE that we could suggest that that gets used as well because that would highlight some social and emotional issues.

Our big issue is that even though all of the zero-to-five teachers are screening the kids - great - I'm not a professional, but I have used this tool and this is a red flag that your child might have some developmental delays which could include autism, but I'm not a professional, so, I can't tell you that your child does, but I highly recommend that you go to these services that are in this area.

Now, we can't do anything after that. After that, if the parent doesn't--you know, a lot of the times, it takes a parent hearing that information three times before they actually follow

through because it's not something they want to hear.

MS. BROWN: Right. There's a level of denial.

MS. SAVCHICK: Yes, but if there is some way that we could help support between sharing the results of the screeners with the parents and, then, somebody to help support the family hear it and go to the next step because the teachers can't do anything.

MS. RUNYON: I think that Free Care is going to be a beautiful bridge because, in my experience in a school, even if a parent is willing and ready to allow their child to receive services, sometimes by the time you go through all of the screeners and all of the things to put into place an IEP, you've gone six months before you have services and that's in a good situation and that's with a family that is advocating.

MS. SAVCHICK: And a school system that supports it.

MS. RUNYON: Absolutely, and that's not talking about our highest level of vulnerable kids that are transient and we start back at square one.

So, if we were able to advocate

that our school districts really embrace Free Care, then, they will have the ability to offer services inside of the school to bridge that gap. And while those kids are receiving services, there can be a need there without that specific diagnosis and those communications can start happening between whether or not there's a mental health clinician inside of the school, working with the family, that will overcome the barrier of that level of denial and, then, we'll be able to reach an appropriate diagnosis while also serving the kid inside the school.

I think that we're moving in a direction that's going to allow our kids to be better served inside the schools. I don't know how that translates to their extended care outside but it's a step.

MS. SAVCHICK: Because you've got to get the teachers supported on what is the system they're using with their behavior at school and getting the parents, the families doing the same thing. They all need to be on the same boat.

MR. CURRY: And there's a lot that the schools are doing well in some areas and, then, there's a lot to be learned, I think, as well and there's ongoing training going on with schools,

opportunities for increasing their capacity but, again, that has been a struggle. Some school districts are just not as embracing.

MS. RUNYON: Some of them have financial barriers and I think some just have--they don't have the same level of funding that would allow them to support the students in the way that they would like.

MS. BROWN: Does autism manifest, though, in a school setting? I mean, doesn't it affect how these kids are learning or are some just fine and it's kind of hidden? I don't know.

MR. CURRY: It's a spectrum. So, you have some kids that you wouldn't even know. You have some kids that they're a little quirky. Teachers go, oh, this kid is a little quirky but they're probably Asperger's on the spectrum, but they may go undiagnosed all the way to kids that are undiagnosed that have sometimes even some very severe emotional disabilities and they may be in a classroom but no one has ever diagnosed them with autism or realize that the behavior might be more social cues and other things. So, it's across the board.

DR. POWELL: Can I ask a

follow-up question? I'm just curious when you were saying the Free Care and how that might help to address some of these. What else would that look like? I'm just trying to envision who would be providing those services and what that would look like because I'm going to play the Devil's advocate.

On the other side which is why I push so much for early identification and intervention because sometimes we get kids and they've been in behavioral health treatment for two years and nobody has given a diagnosis and they have very challenging behaviors.

Well, time out and traditional parenting strategies for those kids is not going to be effective and not what would be clinically indicated.

So, I'm trying to think, okay, what would that look like and who would provide those services if we could support them?

MS. RUNYON: My hope is that-- well, first of all, who would provide those services is any licensed provider that can bill Medicaid. My hope is that these licensed providers are very educated on the screeners and that it's going to be your LPCC's, your licensed clinical social workers.

Any licensed mental health care provider is going to be underneath the umbrella.

So, it's not necessarily going to be a school psychologist or a counselor because they're not currently billable through Medicaid.

And I would hope that if there are behavior cues that would trigger the need for those services, typically, a parent is more likely to agree to services inside of a school if it doesn't come yet with a diagnosis and if you're not trying to umbrella a child in an IEP and say that they need an Individual Education Plan, at least with our resistant parents that aren't advocating.

So, if we're just offering a solution to maybe the phone calls home every single day or we're trying to help with the principal's office, then, these providers can then give these services because they're billable.

And, so, the school can afford to have additional providers inside the school setting where now, honestly, our mental health care providers are spending all of their time on threat assessments and crisis management and now we're going to have funding to be able to have more providers inside of the school.

They meet with the student however many times and realize maybe the first time within ten minutes, this child could benefit from having some screeners and that's when that conversation gets started, I would hope, with the parent to allow a further diagnosis and, then, go from there.

I'm definitely not hoping that it masks or Band-aids anything but that it leads to more care.

MS. KALRA: And if there is something identified, I see this as a resource to work with the FRYSC's with connecting the FRYSC's to other further outside resources that are necessary. So, there's definitely ways that it can be coordinated and best used for follow-up care and not just a Band-aid really.

MS. SAVCHICK: I have a question, if I heard this right. Pre-care is going to cover services that Medicaid does not cover?

MS. RUNYON: No. The Free Care Rule was actually removed in 2014 by CMS. However, it was up to the states to send in a State Plan Amendment in order to allow the individual states to start offering services inside of a school that are

not umbrellaed under an IEP.

So, right now, all services that we are providing to students that are billable - we can still provide services but schools just aren't receiving funding for it. It has to be underneath an IEP.

So, if you have a family that is resistant of having a "label" or something that would put them in this IEP, they just need some time to get there, this is an avenue to be able to provide services for children that are not inside of an IEP as long as they are deemed medically necessary and they are given by a licensed provider and it's a billable service.

And, then, from there, clearly you would want to move towards an IEP if that's what is necessary for the child, but if it's not and it's just an acute outside of autism, if it's just an acute need, you can service the child there. And the goal is to see more providers working inside the school system because there's now a funding stream.

MS. SAVCHICK: Okay, because when you have a lot of trauma in your life, sometimes the symptoms that come along with that can sometimes mask the autism or parents will just default - oh,

this must be autism when, in fact, it's a lot of trauma.

And, so, I'm thinking----

MS. RUNYON: Or vice versa.

MS. SAVCHICK: Or vice versa, correct, and that having these--no one is there to help them unless they have autism and they can go into IEP or they have ADHD. So, they're always looking for something so that they can get an IEP. And I'm wondering if the--is it called pre-care, p-r-e care?

MS. RUNYON: Free care. I don't think that the motive in any way is to--I don't think that there's any motive in any way to push towards IEP, pull away from IEP.

I think it is absolutely 100% just to offer an additional way for children to receive any service that they may need that would reduce any barrier that they may have inside the school setting because we are seeing that there's an increased need for mental health care specifically.

Senate Bill 1 was passed March 11th, 28th, one of those days. It was not attached to a funding stream. So, what really fueled this was that we were trying to offer additional supports for

the new mandates that the schools had; but along with that, we found that this is going to offer more than just mental health. We will be able to offer immunizations inside the school.

The only caveat is that if you offer it to a child that is enrolled in Medicaid, any service, you have to offer it to the entire student body. So, it's up to districts to decide how they want to use this. We're by no means coming from the Cabinet in any way and saying you must implement this in your school district.

We're saying this is an additional vehicle which in most cases, in most places, this is absolutely going to be beneficial, but we're not forcing it. We know there's a lot of schools that have FQHC's and they're running perfectly and it's not broken. We're not trying to fix it, like remain as you are if you'd like. This is just an additional way to get services to kids.

Sorry if I got off track.

MR. CURRY: No. That's fine. I'm glad to know a little bit more about it.

MS. KALRA: And there's sixteen other states doing this. So, it's not like we're the pioneer. Oftentimes we are but this is something

that other states have figured out, especially states in the South. So, it's great to kind of jump on that and utilize that as a prevention tool really when we're talking about before it gets too far, let's try to mitigate that by offering services at the school setting.

MS. BROWN: Is this the place right now for----

MS. RUNYON: So, right now--and you can jump in at anytime.

MS. BROWN: You're doing great so far.

MS. RUNYON: So, right now, we have a State Plan Amendment that was submitted April 28th and it is currently off the clock, but when I say it's off the clock, I would expect it to be finalized in October.

We had a call with CMS last week and I had the opportunity to be on the call, and basically CMS just wanted a couple of additional items added in and it was really just the Random Moment Time Study, as well as a way to configure back-in ratios, how many kids are Medicaid enrolled versus how many kids are not and how are those services being administered.

Those are currently as we speak being written in, resubmitted. We will be back on a call with CMS in a week or two and we expect the State Plan Amendment to be finalized. It will be retroactive to August.

So, I had the opportunity to speak to the District Health Care Coordinators in a district region this morning in Lexington and they were incredibly excited because a lot of the mental health services that they're providing currently are by licensed practitioners and they are to students outside of an IEP and they will actually, in fact, be able to retroactively bill for those services all the way back to August 1 of this year.

MS. BROWN: You did a fine, fine job, very thorough. Thank you.

DR. POWELL: Can I ask one more follow-up question about school daycare. I know it's such a struggle, these kiddos who aren't old enough for preschool yet, can't make it in a typical mainstream daycare, not eligible for medically fragile like Kids Club. They don't take kids with an autism diagnosis.

Is there anything sort of in the works to think about, any kind of specialized

daycare for kids with any kind of disability but autism in particular? It is a real struggle. I don't know if you've seen that.

MR. CURRY: Absolutely, and especially in my previous work in early childhood mental health. There's not anything that I'm aware of.

There are places that are doing some good work around that. I think some school districts are starting to look at the need for that wraparound care and providing more than just the state-funded preschool for three and a half, four hours a day.

DR. POWELL: Because like you said, then, the parents, they can't work or somebody can't work. Again, I don't have any data on this but I do always worry about these kids and their risk for abuse when they are left with this person and this person because the parents are trying to work and there's no daycare available for these kids.

MR. CURRY: And the Governor's Office for Early Childhood, they've had the preschool grant that they've been looking at expanding some of that work but I've been out of that world for the last year.

DR. POWELL: Other questions anybody have? I know you need to be in Lexington soon, so, I want to be mindful of your time, but anybody else with questions?

Thank you so much. We really appreciate your time and I know you're going to touch base with Dr. Barnes before he comes to us next time and we can continue our conversation.

MR. CURRY: The other points on here, we're just pointing out that if you were looking at data and looking at I think there's still going to be opportunities to comment on other pieces of the Medicaid redesign.

As that continues to unfold, there will be other pieces that come out that there will be public comment is my understanding and that is certainly an opportunity for this group.

MS. BROWN: Yes. Take those opportunities. They need the feedback, absolutely. Thank you.

DR. POWELL: Thank you. So, we're going to go backwards on the agenda.

MS. KALRA: We have a quorum.

DR. POWELL: We do have a quorum. So, we actually need to go back. I know

Sharley sent out all the minutes, so, hopefully, everybody got those. We need to actually approve minutes from May and July this time. Anybody have corrections, amendments, anything they saw that wasn't accurate?

MS. KALRA: Go ahead and approve.

DR. POWELL: Okay. So, we need a motion to approve for May and July.

MS. KALRA: I approve.

MS. SAVCHICK: I second.

DR. POWELL: Thank you. Do you want to go ahead and give an update from the MAC?

MS. KALRA: Yes. So, the MAC met in July. We did finally receive a guidance on videoconferencing. So, that is huge because we've been waiting for that for a while and we know that a lot of our members can't often attend since we're all across the state.

So, DMS will not provide assistance on videoconferencing. So, if we do have any videoconferencing needs, we will have to do that on our own and that is just what we received via email. You all as TAC members should have received that email as well.

I don't know what to say other than the fact that if you have questions, we could reach out to DMS to clarify any of them. I don't know how often you guys carry a projector or a monitor or anything along your rides here but that's something that we would have to do if we want to explore videoconferencing.

DR. POWELL: Or pay the ITE.

MS. KALRA: Or pay the ITE.

MS. BROWN: We simply don't have the capacity. The rooms that are the size for the MAC don't have the technical capacity. It would involve renting, procuring equipment, etc., things the State has cumbersome and expensive processes for. So, that's the bottom line on that.

MS. KALRA: So, if we have any additional questions, feel free to shoot them over.

MS. BROWN: We do pay expenses for traveling to the MAC.

MS. KALRA: Well, some of our folks here travel from the western part and eastern part of the state and they work with patients. So, it's often hard to travel here just for an hour and a half. So, that's where we thought videoconferencing could actually help.

MR. CURRY: Sorry to ask. Are there requirements around what it has to be because you could set up a Zoom call.

MS. BROWN: Legally it can't. To meet the Open Meetings' requirements, everyone has to have access to the same----

MS. KALRA: Function.

MS. BROWN: Exactly. Skype, an individual Skype doesn't meet the requirements for that.

MS. KALRA: And you have to see each other at all times. So, everyone would have to see each other as well.

MS. BROWN: There are all kinds of legal boundaries on this topic under Open Records and Open Meetings' laws.

MS. KALRA: So, we finally have our answer to that or somewhat of an answer.

And, then, we also had three MCOs presentations in July which were Aetna, Anthem and Humana. If you all haven't received those and are interested in receiving those copies, I'm happy to share that with this group as a follow-up.

DR. POWELL: That would be good. We didn't get it or this group didn't get it.

MS. KALRA: Okay. I will make that as a to do of mine.

MS. STEPHENS: And it may be already posted on the website.

MS. KALRA: Okay. Perfect. Well, I will at least direct you to that page, then.

Also, one other update. You all have probably received the email about dates continuing on for this TAC. And what Lisa and I have talked about is continuing on with what we already have scheduled, meeting the second Wednesday of every other month for 2020.

So, we'll figure out those dates once they are finalized and shoot those out to you.

DR. POWELL: So, just so we can kind of tentatively but they haven't been finalized - I think we have to get final approval from Sharley when she gets back - but it should be January 8th, March 11th, May 13th, July 8th, September 9th and November 11th for 2020. So, as soon as they are finalized, we will send it.

MS. KALRA: And, then, one last thing. There was an email sent out about open meeting guidance. So, if anyone wants to know what

the law is and what we need to----

DR. POWELL: I think everybody should have gotten that, the open meetings.

MS. KALRA: So, all of our agenda should be public. All of our dates should be posted. So, if anyone has any questions, it should be on our page.

I think that is all my updates from the MAC.

MS. STEPHENS: I just checked the website and they're posted.

DR. POWELL: Thank you. Okay. So, just any roundtable updates or concerns from members?

MS. DIMAR: No concerns. We're working on finalizing our legislative priorities for the coming year health- and safety-related. We're wanting funding for SB 1 and they being our two top health and safety ones. We have other educational ones but early childhood education is one of them.

DR. POWELL: When is that? What's your time?

MS. DIMAR: We have to approve it at our next Board meeting. So, we're just working on that. And we have an advocacy training every

November. We've done that for years just training parents to be better advocates for their own children in their schools and their communities.

DR. POWELL: Great. In terms of the Kentucky Psychological Association, we already touched on this, but still lots of questions and just concern about new codes from CMS, both the psych testing codes that I refer to and now CMS has new health and behavior codes that will be coming out in January of 2020 and there are lots of new ones and it's changed exponentially. There's not add-on codes sort of similar to what they did for psych testing codes.

So, all of our coders and providers are all going crazy trying to figure out when all the codes will be loaded and ready to go. So, that's our biggest challenge and concern for providers.

MS. KALRA: I don't think that we have a concern at the moment. One big update is our Kentucky Kids Count Data Book is coming out in November. So, at the next meeting, I'm happy to bring some over.

Every year, we publish the County Data Book that has sixteen data indicators

that span from health to economic security and they are a great tool for you all if you're looking for data. And, then, our Kentucky Kids Count Data Center also will be updated in November with new data sources and new indicators and we have over 100 indicators on then website but nobody wants to read that in a book. So, we just kind of condense it to sixteen that are specific to child well being.

So, hopefully by the next meeting, I will have plenty of copies for everyone to review. And if anybody is interested, we could even do like a short mini presentation on that. So, if that's something that this group is interested in, we are happy to do that as KYA.

And, then, we are also finalizing our Blueprint for Kentucky's Children Policy Agenda that we put out every year. That will be announced in December but we have a couple of issues that relate to health, a couple being with E-cigarettes, school safety as well.

So, you'll be on the lookout and you'll hear some more from me at that time, but I think that's really it from my end.

DR. GRIGSBY: I was not equipped with specific concerns from our organization

to come to the meeting but I will certainly make sure that I have those. I think the organization is working on a lot of health priorities for the children of the state, and it's interesting that you mentioned vaping because I think that has become a very big area of concern in our organization.

So, just continuing on with the priorities that have been in place with addressing some of the issues that are most concerning to the children of our state like obesity and child abuse and violence and things like that.

MS. SAVCHICK: Last month, we brought up the CBD concerns and we definitely have interest in the autism and how we can help partner and communicating it to teachers and preschool families as well.

So, as we're going around the state and having Super Saturdays and we're working with some libraries and presenting, if we can be more intentional and specific on how we are addressing the issue with families and helping to communicate the need that's out there would be good.

MR. FLYNN: And for us, actually vaping is a big issue in schools and Family Resource Centers are getting taxed with that

constantly trying to figure out ways of educating parents and students on the dangers of vaping and the prevention of that.

So, that's one of the things that we are actually focusing on right now, too, but, then, the big thing we're doing statewide right now is just implementing the standards of quality and for family strength and support and basically it's just making our centers more responsible for making sure that all the programs that are offered and services that are offered are of high quality and we're training every coordinator in the state to identify where they are and, then, helping them to make a plan to step up the quality of those programs and services, or if they're not quality at all, then, just removing them completely.

DR. POWELL: So, vaping keeps coming up and we had talked about that last meeting, too, and vaping and autism and CBD and those things kind of were our biggest topics.

So, it sounds like that's still a huge priority for lots of people. So, maybe after we work on the autism, maybe we try to think about some speakers and think about looking at some data around vaping, too.

So, if anybody has thoughts about people that we could bring in with that, let me know.

MS. KALRA: The Foundation for Healthy Kentucky and there's a couple of other groups that we could reach out to.

I know that several of you have mentioned vaping, and we have a Powerpoint that we've developed for not only students but also for parents as well. So, I'm happy to share that. It's very basic but just bringing awareness of like what vapes look like, what is it, the amount of nicotine that's in it. That seems to be common questions of parents and, then, also youth do not realize and understand.

So, we've actually worked with the Department for Public Health and the Foundation for a Healthy Kentucky in developing these Powerpoints. And, so, I'm happy to share those since they're finalized now. So, if that's something that you all need.

DR. POWELL: So, we will put that on the agenda to address vaping and we'll look for some resources and speakers as well.

Old Business. I think we're going to hold on this. Sharley had sent along this

handout that----

MS. BROWN: I'm happy to discuss it with you.

DR. POWELL: Okay. Great, great because I know she was going to do that but that's perfect. Go ahead.

MS. BROWN: We do have this amazing program. I really think this has the capacity to help so many families because what it does is if a household has at least one member of it eligible for Medicaid benefits, and we're hoping that foster care families will take advantage of this opportunity, and someone else in the household has access to an employer-sponsored health insurance plan, that what we're finding is a lot of times, working parents won't pay for the premium for the employer-sponsored health insurance plan because it's expensive for the family.

Medicaid has found that it benefits our program if we can access that employer-sponsored health insurance plan for the family and pay the premium for it, and, so, get a working family into an employer-sponsored health insurance plan even when they can't afford it if they have a Medicaid member in the household.

What we have found is it provides such a cost savings to Medicaid for us to pay that premium for that family plan that we're willing to do it, and the only problem is you have to identify yourself as potentially being eligible for this and let us know.

And, then, we do a cost benefit analysis comparing and contrasting the benefits and the cost of Medicaid versus this employer-sponsored health insurance plan; but if the numbers work, we end up paying the premium and getting that family off the Medicaid rolls and into employer-sponsored health insurance which provides huge benefits.

I mean, they have access to care they couldn't get. They have a network that might be expanded in some way and it provides a huge cost savings to Medicaid.

If you look at the bottom of that page, as of September 10, we had 165 members enrolled. We started enrolling them July 1. We had an average savings to Medicaid of $325 per month per person and almost $4,000 a year per person.

And, so, it's a fantastic program. We're hoping that our foster care families will take advantage of this. We actually have quite

a number of people who work in state government who qualify for this program.

We're just hoping to find those working families who are still on Medicaid in some fashion but also have access to but can't quite reach to afford the employer-sponsored insurance.

We're trying to bridge that gap with KI-HIPP and get them onto the program that their employer can give them access to because it provides a new level or responsibility for someone who works to see, wait, I can get these benefits and then look at what this does for my family. It kind of is a way of encouraging moving away from the Medicaid rolls.

So, anyway, we're trying ot get the word out. It's a complex message and we're working on spreading it wherever we can. And, so, if you work with people or if you are a teacher, this is a fantastic program for the working poor as we would define them under federal and state law.

In Michigan, for example, there are nearly 40,000 people in a program that's designed this way. And in Kentucky, we project that the need is for about 30,000 families to be served in this fashion. And, so, we're just working on identifying where they are and whether they have access like we

think they possibly do to an employer plan.

DR. POWELL: Can you say more? I know it says to submit the eligible document. So, do they go online?

MS. BROWN: Yes. On our website, if you go to CHFS.ky.gov, on our website, you can search KI-HIPP. You'll get the page, you'll get the links. You can apply online. You can call someone in Medicaid.

You can call Teresa Shields, our third-party liability coordinator, but somebody will answer the phone if you call the number that's there and walk you through it or help you submit the a paper application if you don't have a computer handy. So, there are lots of ways to access it.

MS. KALRA: A clarifying question. If the employer doesn't cover a service that would be covered under Medicaid, would Medicaid cover any wraparound services?

MS. BROWN: That question Teresa could answer for sure but I believe there is that availability, but we're finding in most cases, the employer-sponsored insurance plans cover more because in Kentucky, we've got regulatory standards for what the insurance companies must provide and

it's much broader than what we're able to provide in Medicaid.

There's a possibility that if there's a specialized service that Medicaid is covering, yes, and I think in those cases, that's where the cost benefit analysis comes in.

MS. KALRA: Okay. And, then, so, if there's a child involved, sometimes KCHIP offers services that might be more expansive or more--that KCHIP offers a great deal of services----

MS. BROWN: Exactly.

MS. KALRA: ----that an employer probably wouldn't cover.

MS. BROWN: Well, it depends. As I said, Kentucky has state standards. We only allow a few insurance companies to write insurance plans in this state. We have a highly regulated insurance market, and our standard package of benefits is--what the State requires these plans to offer us is quite extensive. So, I don't know if you would really run into that kind of a situation.

Private insurance is, what would you call it? It is heavily populated with benefits in Kentucky. We have mental health benefits, substance abuse benefits just as standard

parts of the package.

DR. POWELL: Great. Questions about KI-HIPP. Thank you.

We talked about Free Care. I don't think we have yet any other update. We've talked about polypharmacy. We made the recommendation and got the response that we talked a little bit about last time.

I do think it might be a good idea for us to circle back to see if there's other--you know, we were looking then for other action items and sort of next steps, and I know that we got a lengthy response. So, it might be worth--maybe we'll send an email follow-up to see what we can do next on that.

Any other Old Business or things we didn't touch on today? I don't think we have any data requests or anything else. Do we have any data requests?

MS. KALRA: No, we do not but I will make sure that we have our next data request that we'll send over.

One other thing. There's MCO forums happening across the state. I got an email about that and all TAC members should have. Do you

know, is that going on just in October? Do you register? How does that process work?

MS. BROWN: I can get you more information on it because I've only seen a few emails on it, but I believe there are a few in every state park or most of the state parks throughout the state and they're throughout September, October and I think early November as well.

And, so, it's a day where you can go to the state park and hear a presentation from the MCOs and ask questions of Medicaid staff and MCO staff on Medicaid. I can get more information to you if you would like that.

MS. KALRA: I think that would be helpful.

MS. BROWN: Okay, and, then, you can share it with your membership.

MS. STEPHENS: And I'm really not trying to promote the website but it is out there, too, and they start, the first one is on September 30th at Dale Hollow and then they end up I think in Frankfort October 17th.

MS. BROWN: And thank you for bringing up the website. We have been working hard on getting it updated. I'm thankful that you brought

that up because it is out there.

DR. GRIGSBY: I think Sharley sent that out to us. She sent the dates.

MS. BROWN: She may have. She may have sent you the dates. There's a flyer that summarizes all the information. It's probably posted on the website and I think Sharley may have mailed it, too, but I'll make sure you get it.

DR. POWELL: Any other Old Business, New Business, anything?

So, next time, we are meeting in November, November 13th and we will hear from Dr. Greg Barnes. We will hopefully have some data from MCOs and continue the conversation about autism.

I'm going to apologize in advance. I'm going to be late. So, you all don't wait for me to start. I have another presentation that I will be coming from.

If there's no other New or Old Business, we need a motion to adjourn.

MS. DIMAR: So moved.

MS. KALRA: Second.

DR. POWELL: Thank you all.

MEETING ADJOURNED